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February 6, 2012

Marie Godley, Administrator
Northern Idaho Advanced Care Hospital
600 North Cecil Road
Post Falls, ID 83854

Provider #132001

Dear Ms. Godley:

On **January 26, 2012**, a complaint survey was conducted at Northern Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005181

An unannounced visit was made to the hospital on January 23 through January 26, 2012. During the complaint investigation, surveyors reviewed ten patient records, including five records for discharged patients and five records for current patients. Administrative documents were reviewed, including hospital policies, incident reports, and documentation of patient complaints and grievances. Physical therapy, occupational therapy, and speech therapy services were observed being provided to a brain-injured man. Nursing staff, therapy staff, a pharmacist, and administrative staff were interviewed. Patients and caregivers were interviewed, including five current patients, a parent of a current patient with a serious head injury, and a discharged patient and his family members.

Allegation #1: There was an unreasonable delay in providing pain medication after admission to the hospital.

Findings #1: A review of records, staff interview, and interview with current patients and their families indicated hospital staff routinely attended to pain management, evaluated the effectiveness of medications, and adjusted dosages and types of medication in order to effectively manage pain.

One record documented a 35 year old male who was admitted to the hospital on 8/04/11 after transfer from another facility. He had a history of a gunshot wound to the head, chronic back pain, was in acute respiratory failure, and on a ventilator. At the prior hospital, the patient had been on Dilaudid (an opioid narcotic) 0.2 mg (milligrams) per hour IV (intravenously). The initial RN Admission Assessment was conducted on 8/04/11 at 4:05 PM. The RN documented the patient did not appear to be in pain at the time of the initial assessment.

The initial physician's orders for pain medication, dated 8/04/11 at 4:52 PM included:

Fentanyl (an opioid narcotic) 50-75 mg IV every 2 hours as needed for pain and
Oxycodone (an opioid narcotic) 10 mg per gastrostomy tube every 3-4 hours as needed for pain

In addition to pain medication, the initial physician's medication orders included an order for Haloperidol 5 mg IV every 4 hours as needed for agitation.

On 8/04/11 at 5:45 PM Oxycodone 20 mg was documented to have been administered;

On 8/04/11 at 8:00 PM, nursing notes documented the family was at the patient's bedside expressing concern regarding the patient's medications, stating the patient was on Dilaudid a Patient-Controlled Analgesia (PCA) pump at the prior facility and they were concerned he did not have orders for the same. The nurse told the family other medications had been ordered to manage the patient's pain and agitation. She told the family she would give a dose of Haldol to decrease the patient's agitation and would re-medicate him with more Oxycodone at 8:45 PM when medication was due. The note stated the family agreed to the plan.

It was not clear from the documentation why Fentanyl had not been administered at the time or whether it had been offered. However, during an interview on 1/25/11 at 9:00 AM, the Director of Nursing stated the patient's wife told her she did not feel Fentanyl was effective and did not care for the side effects.

On 8/04/11 at 8:10 PM, Haldol 5 mg was documented to have been administered IV for agitation.

On 8/04/11 at 8:45 PM, nursing documentation stated the patient remained agitated with elevated heart rate. At that time Oxydone 10 mg was documented to have been administered.

On 8/04/11 at 9:15 PM, the patient's family expressed concern again about there being no orders for Dilaudid.

On 8/04/11 at 9:20 PM, the physician was contacted per family request.

On 8/04/11 at 9:30 PM, new physician orders were written for :

Dialudid PCA 0.2 mg per hour continous basis,
0.5mg Dilaudid IV push every 2 hours as needed for pain, and
Ativan 1-2 mg every hour as needed for anxiety.

On 8/04/11 at 9:45 PM, Dilaudid 0.5 mg IV was administered

On 8/04/11 at 10:25 PM, a Dilaudid PCA was initiated per physician orders.

On 8/04/11 at 11:40, Oxycodone 10 mg was administered for signs and symptoms of pain

On 8/05/11 at 12:15 AM, the patient was observed to be sleeping.

Family was interviewed by telephone on 1/23/12 at 3:10 PM and 1/23/12 at 6:10 PM. Two family members stated the patient was going through withdrawals, kicking at the bed and sweating, from not getting an IV medication for Dilaudid upon arrival at the hospital which, they stated he had been receiving at the prior facility. They both stated the patient was not getting adequate pain relief and the physician was not listening.

A Case Manager note, dated 8/05/11 at 5:30 PM, stated the physician spoke with the patient's family and attempted to reassure the family that the length of time the patient was without adequate pain medication would not cause the patient to experience any signs and symptoms of withdrawal.

The Director of Pharmacy was interviewed on 1/26/12 at 11:00 AM. She was asked how soon a patient might experience withdrawals when taken off continous Dilaudid via PCA and subsequently put on Oxycodone. She stated if the patient received Oxycodone after being taken off Dilaudid, then he would not likely experience withdrawal symptoms because both drugs were in the same class (opioids). She stated signs and symptoms that could be interpreted as withdrawal symptoms,could result from other factors, such as pain or a head injury.

The Director of Nursing was interviewed on 1/25/11 at 9:00 AM. She stated it was the hospital's goal to help the patient (discussed above) to wean off of the ventilator. Because Dilaudid could depress the respiratory drive it was not the physician's first choice related to pain management. She stated the physician was aware the patient had been on a Dilaudid drip and made a considered initial decision not to put him on Dilaudid. However, after talking with the patient's wife by telephone the evening of admission, he ordered Dilaudid based on information provided

by the patient's family and their request he be put on Dialudid.

Five current patients and family members were interviewed onsite on 1/11/12. Five patients and one family member stated pain was adequately managed and they had no complaints.

It could not be determined the hospital had an unreasonable delay in providing pain medication after admission to the hospital. Therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Nursing staff did not meet patient needs by responding in a timely manner to call lights, helping with toileting needs, hygiene needs, and cleaning patients up after incontinent episodes.

Findings #2: All of the five current patients who were interviewed, including family members of current patients, stated staff was good about responding promptly to call lights with only an occasional delay. They expressed satisfaction with the help they received related to toileting and hygiene needs.

One patient who had been discharged several months prior and two of his family members were interviewed by telephone on 1/09/12. The patient and his family members stated he was left in his own feces and did not receive adequate help with hygiene needs.

One record documented a 35 year old male who was admitted to the hospital on 8/04/11 after transfer from another facility and discharged on 8/12/11. He had a history of a gunshot wound to the head, chronic back pain, was in acute respiratory failure, and on a ventilator. His record documented varying levels of hygiene care from day to day. For example, nursing flow sheets documented the following:

8/04/11 - a bed bath, linen change, catheter care, oral care, peri-care (cleansing of the genitals and rectal area)
8/05/11 - bath, oral care, peri-care, skin care
8/06/11 - bath
8/07/11 - bed bath, oral care three times, peri-care twice
8/08/11 - oral care three times, cath care, peri-care
8/09/11 - oral care three times, peri-care
8/10/11 - oral care three times, peri-care, catheter care, skin care, bath
8/11/11 - bed bath, peri-care, linen change
8/12/11 - oral care, peri-care, assist with bath, linen change

Nursing narrative notes documented additional details related to hygiene care. For example, a nursing note, dated 8/06/11 at 12:00 noon, documented the patient was cleaned of a very large liquid diarrhea stool, including thorough peri-care.

The Director of Nursing was interviewed on 1/26/12 at 10:20 AM. When asked how the hospital ensured adequate nursing staffing to attend to patient needs, she stated staff had a "Heads Up" meeting every morning to discuss patient needs. Nursing staff worked together with Patient Care Technicians to respond to patient needs. She stated either nursing staff or Patient Care Technicians could respond to a call light and help with hygiene needs. Additionally, she stated, supervisors were available as back-up, and the hospital staff had been working on improving teamwork, which had improved coordination of care to better meet patient needs.

Five current patients and a family member were interviewed. All stated their hygiene needs were met.

It could not be determined the hospital was not responding to patient needs in a timely manner and attending to toileting and hygiene needs. Therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The hospital did not provide enough therapy services. Physical therapy did not include exercise.

Findings #3: Patient records that were reviewed documented appropriate physician orders for therapies. They also included established plans of cares including interventions and goals that were approved by an Interdisciplinary Team. Therapy notes indicated therapists followed the approved plans of care.

The Therapy Director was interviewed on 1/26/12 at 10:40 AM. During the interview, he was asked to explain the type of therapy conducted for patients who had sustained brain injuries. He explained that "neurological rehabilitation" (such as for individuals who have had brain injuries) was different than "regular rehabilitation." He explained that keeping stimulation low was generally recommended when a person has had a brain injury. They generally limited sessions to a maximum of 30 minutes per therapy discipline 5 days per week. He also explained that therapists had a daily schedule that included appointments every 30 minutes. Sometimes, he explained, a patient might be scheduled for up to 60 minute appointments, if they were able to tolerate working that long or if more than one discipline was working with the patient at the same time. He stated sometimes it was necessary, because of patient needs, to schedule different therapy disciplines to work with the patient at the same time, such as a physical therapist and occupational therapist working together during the 30 or 60 minute session.

The Therapy Director explained it was the goal of therapy staff to move patients through the "Rancho levels." He provided a patient handout, "Family Guide to The Rancho Levels of Cognitive Functioning" and stated patients and families are provided this information, as appropriate. It is an evaluation tool used by the rehabilitation team that describes eight levels of functioning and the patterns or stages of recovery typically seen after a brain injury (one is the lowest level and eight is the highest level).

The Therapy Director made it possible for the surveyor to observe a therapy session with a 20 year old male who had suffered a serious brain injury. The therapy was being provided by a speech therapist, occupational therapist, and physical therapist. The patient's mother was also present during the therapy session which lasted about an hour. Activities involved balancing on a large ball with assistance, lifting arms enough to place a ball in a basket, gentle rocking, and mouth work. The session did not look like typical exercise. The therapists explained the need to work on basics with brain injured patients, like the ability to control one's trunk, hold up one's head, the ability to form words. He stated these type of goals were necessary to achieve before more complex tasks could be accomplished.

One record documented a 35 year old male who was admitted to the hospital on 8/04/11 after transfer from another facility. He had a history of a gunshot wound to the head, chronic back pain, was in acute respiratory failure, and on a ventilator.

The "Interdisciplinary Plan of Care," included a plan for occupational therapy 3-5 times per week with interventions geared toward goals for the patient to be able to groom and dress himself sitting and standing, and use a bedside commode with assistance. There was also a plan for physical therapy 3-5 times per week with interventions geared toward goals for the patient to be able to move in bed, sit up on the edge of the bed for 15 minutes at a time, and tolerate being up and out of bed for up to an hour per day.

According to the Therapy Director, the patient started out at a "Rancho Level II" and within one week reached a "Rancho Level IV." He stated the patient made remarkable progress for such a short time and was prepared to transfer to a rehabilitation program where he would be required to participate in therapy for 3 hours per day.

The patient's medical record documented occupational therapy sessions, physical therapy sessions, and speech therapy sessions, were provided according to the plan of care approved by the Interdisciplinary Team and had been ordered by patient's physician. The patient's status was improved at the time of transferring on 8/12/11 to a rehabilitation facility.

There was lack of evidence to show the hospital did not provide enough therapy services to meet

patients' needs. Therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Patients were inappropriately left off oxygen for hours while in a wheelchair.

Findings #4: Patient records were reviewed to see if oxygen use followed physician or nurse practitioner orders and were consistent with the plan of care approved by the Interdisciplinary Team. Documentation in patient records indicated consistency with orders, plans of care, and patient goals.

One record documented a 35 year old male who was admitted to the hospital on 8/04/11 after transfer from another facility. He had a history of a gunshot wound to the head, chronic back pain, was in acute respiratory failure, and on a ventilator.

Physician orders, dated 8/04/11 at 4:30 PM, documented orders for staff to adjust oxygen usage to keep oxygen saturation rates above 90%.

Physician progress notes documented the patient was breathing through a ventilator until 8/08/11 at which time he was taken off of the ventilator.

A nursing progress note, dated 8/11/11 at 2:00 PM documented the patient's respirations were regular and unlabored, his breath sounds were clear, and he was able to be up in a wheelchair with his family without the need for oxygen.

The Clinical Compliance Specialist, an RN, was interviewed on 1/25/11 at 8:00 AM. She explained orders were written to adjust oxygen based on oxygen saturation levels and that the oxygen saturation levels were routinely checked every 4 hours and on an as-needed basis on the Medical-Surgical unit. She stated a goal for the above referenced patient was first to get him off the ventilator and then off the need for oxygen. She explained if oxygen saturation levels were above 90% on room air, then oxygen was not needed and did not have to be worn.

It could not be determined patients were inappropriately left off oxygen. Therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The hospital did not provide adequate discharge planning activities. This resulted in unnecessary delays in transfer to other facilities. The hospital tried to block or delay transfer of patients in order to keep insurance money.

Findings #5: Although the entire team contributed to discharge planning, Case Managers assumed primary responsibility. Review of patient records documented ongoing discharge planning activities, including discussion with patients and families related to options for discharge, coordination with insurance companies to determine and verify benefits, and coordination with potential receiving facilities to determine criteria for acceptance of patients and to ensure patients met certain criteria to be safely transferred to a different level of care.

One record documented a 35 year old male who was admitted to the hospital on 8/04/11 after transfer from another facility. He had a history of a gunshot wound to the head, chronic back pain, was in acute respiratory failure, and on a ventilator. There was extensive documentation in the patient's record by the hospital's Case Manager (social worker/discharge planner) related to discharge planning, communication with the patient's family, the insurance company, and the expected receiving facility.

8/05/11 2:30 PM: The Case Manager's note documented she talked to the patient's family to discuss goals for the current stay and eventual discharge disposition. The note also documented the patient's physician talked with the family about the patient's care and needs.

8/08/11 at 3:15 PM: The Case Manager documented she would pursue the family's desire for transfer to a rehabilitation facility. She documented contacting a representative from the potential receiving facility and faxing information to the receiving facility that was current as of that day (8/08/11).

8/09/11 at 12:00 PM: The Case Manager documented talking with the patient's wife, gleaning additional medical information and faxing updated information to the potential receiving facility so the other facility could evaluate the information to see if the patient would qualify for admission.

8/10/11 at 11:00 AM: The Case Manager documented speaking with a representative from the receiving facility who stated information was under review. She also documented communicating with patient's family.

8/11/11 at 4:00 PM: The Case Manager documented further communication with a representative from the receiving facility and with the insurance company regarding the pending discharge.

8/12/11 at 9:55 AM: The Case Manager documented further telephone communication with a representative from the receiving facility, informing that transport to the receiving facility had been tentatively scheduled for 2:00 PM that afternoon. As of that time, the receiving facility reported they had not received authorization from the insurance company to approve the transfer.

The Case Manager documented calling and speaking with a representative from the insurance company who stated a higher level of authorization was required because the receiving facility was "out of network."

A nursing progress note, dated 8/12/11 at 2:30 PM, documented the patient was transferred to the receiving facility.

The Director of Nursing was interviewed on 1/25/11 at 8:00 AM. She explained that it was the goal of the hospital to help this patient qualify to transfer to a rehabilitation facility. She explained that in order to qualify, he had to be off the ventilator and able to tolerate 3 hours of exercise per day. She stated he was transferred, upon the family's request, as soon as he qualified. Although he had been off of the ventilator since 8/08/11, he had not progressed in physical therapy to the point that he would have qualified to be discharged any earlier than he was discharged. They expressed satisfaction with discharge planning services.

Five current patients and/or family members were interviewed during the day on 1/11/12. Patients and family members stated the hospital staff had been talking to them about discharge planning, although, decisions had not been made in all cases.

There was lack of sufficient evidence that the hospital did not stay current with information provided to receiving facilities. Documentation was thorough and ongoing and indicated hospital

staff worked to facility appropriate transfers and support patient/family wishes. Therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa Hamblin, RN, MS Sylvia Creswell

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Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
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TH/srm

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February 17, 2012

Marie Godley, Administrator
Northern Idaho Advanced Care Hospital
600 North Cecil Road
Post Falls, ID 83854

Provider #132001

Dear Ms. Godley:

On **January 26, 2012**, a complaint survey was conducted at Northern Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005103

An unannounced survey of the facility was conducted on 1/23/12 through 1/26/12. During the course of the investigation 10 medical records were reviewed, which included five current patient records and five discharged patient records. Staff members and six patients, both current and discharged, were interviewed. Incident reports and grievance documentation were reviewed.

Allegation #1: Patient had a leg decubitus that was not documented upon transfer to another facility.

Findings #1: One record documented a 49 year old female who was admitted on 3/08/11, after transfer from another hospital. The admission assessment documented the patient had a wound to her hip area, as well as, a wound on her leg. Notes from the nursing staff and the wound care nurse documented dressing changes to wounds on each leg during the patient's five week hospitalization. Nursing notes the day before discharge included documentation of lower extremity decubitus with scabs. The note lacked clarity as to which leg was referred to, and did not include the actual appearance of the decubitus.

Discharge documentation by the wound care nurse included instructions for wound care for the patient's hip area only. The Discharge Instruction sheet, under the heading "Skin Care," included boxes to be checked beside options such as "Skin Intact; no identifiable concerns" and "Other skin care." The boxes in the skin care section were unmarked. The discharge record did not indicate the patient had leg wounds upon discharge.

Review of the receiving facility's Admission Assessment, documented the patient had three skin tears on her lower left leg, and one hematoma/skin tear on her lower right leg that were present upon admission. The assessment included a comment "Skin tears d/t (due to) banging legs against side rails." The record did not indicate the patient had a decubitus on her leg.

Although the patient was not documented as having leg wounds at discharge, the receiving facility provided documentation of leg wounds.

Current records of patients who were to be transferred to other facilities indicated thorough and comprehensive documentation of wounds. While the event occurred, the facility had made changes to improve the documentation of wounds. Current practices were consistent with regulatory requirements. Unless current regulatory noncompliance is identified, a complaint is considered unsubstantiated, even if evidence of past noncompliance exist.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patient was discharged prematurely.

Findings #2: Physician progress notes, nursing and case management notes, and discharge criteria were reviewed. It was found the patients were discharged appropriately.

One record documented a patient who was discharged to a long term residential facility for medically fragile individuals. An accepting facility came in to evaluate the patient and her medical record prior to acceptance. After a review of the patient and records, the accepting facility agreed to the transfer. No evidence could be found to indicate the discharge was inappropriate or contraindicated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

SUSAN COSTA
Health Facility Surveyor
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SYLVIA CRESWELL
Co-Supervisor
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